Revised May 2019

Metro Health STD/HIV Risk Assessment Form

In the past 90 days, have you:		
YES	NO	**Had more than one sexual partner?**
YES	NO	**Picked up someone you did not know to have sex with them?**
YES	NO	**Met someone for sex whom you met online? If yes, which ones? _____**
YES	NO	**Exchanged sex for money, drugs, food, shelter, and/or other items?**
YES	NO	**Knowingly had sex with a sex worker/prostitute?**
YES	NO	**Used drugs like crack cocaine, crystal meth, or other IV drugs?** If yes, do you share drug equipment? □ YES □ NO If yes, how many needle sharing partners have you had in the past 90 days? _____
YES	NO	**Have you engaged in any sexual behavior with a person of the same sex (voluntary or involuntary)?**
YES	NO	**Have you had sex with someone you know has Syphilis, Gonorrhea, Chlamydia, Hepatitis, or HIV?** If yes, which one? _____
YES	NO	**Had sex with somebody in a public place like a bar/club, bath house, book store, or public park?** If yes, where? _____
		How often do you use condoms or other protective barriers? □ ALWAYS □ SOMETIMES □ NEVER

Additional Questions.	
My Sex Partners Are: □ Male □ Female □ Transgender	**# of Sexual Partners in past 6 months:** Males: _____ Females: _____ Transgender:_____
In your opinion, what are your chances of getting an STD or HIV? □ Low Risk □ Moderate Risk □ High Risk	**Why do you think you are at this level of risk?**

Please answer the following questions		
YES	NO	Have you ever heard of PrEP?
YES	NO	Are you currently taking daily PrEP medication?
YES	NO	Have you used PrEP anytime in the last 12 months?

CITY OF SAN ANTONIO
METROPOLITAN HEALTH DISTRICT

SAMHD HIV/STD Assessment Form
Clinic

Date of Visit _____

PATIENT INFORMATION

Patient Name: _____ **Date of Birth:** _____

Patient Signature: _____

Social Security #: _____ **Phone #:** _____ **Email:** _____

Address: _____ **Apt #:** _____ **City:** _____ **County:** _____ **State:** _____ **Zip Code:** _____

Race: □White □Black/African American □Asian □American Indian/Alaskan Native □Native Hawaiian/Pacific Islander □Other

Ethnicity:
□ Hispanic/Latino
□ Not Hispanic/Latino

Gender:
□ Male □ Transgender □ Other
□ Female □ Male to Female
□ Female to Male

Sex at Birth:
□ Male
□ Female
□ Declined to answer

Emergency Contact Name: _____ **Relationship**_____ **Phone #:** _____

Do you have health insurance? □ YES □ NO **If Yes, which one?** □ Medicaid □ CHIP □ Private Insurance □ Other

Marital Status: □ Married □ Single □ Polyamorous □ Other **Household Size:** _____ **Monthly Income:** _____

Have you lived or recently traveled outside of the United States? □ YES □ NO If Yes, Where? _____

When was the last time you were at this clinic? _____

Are you here with your partner? □ **YES** □ **NO** **If yes, (Partner's Clinic Number today ____)**

What is your primary language? _____

MEDICAL BACKGROUND

YES NO **For Females:** Are you currently pregnant? **Date of Last Menstrual Cycle:** _____

YES NO **Are you allergic to any medication?** If yes, which ones: _____ Reactions: _____

YES NO **Are you being treated for a medical condition at this time?** If yes, which ones: _____

YES NO **Are you currently taking any medications?** If yes, which ones: _____

YES NO **Do you currently use tobacco products of any kind (including vape)?**
If yes, do you want information on how to quit tobacco use? □ YES □ NO

YES NO **Have you ever been tested for HIV/STDs?**
If yes, which one: _____Date of test: Month _____Year _____

YES NO **Have you ever been told you have HIV, Syphilis, Hepatitis C, Chlamydia or Gonorrhea?**
If yes, which ones? _____When?_____

YES NO **Have you ever been treated for an STD?** If yes, what treatment did you receive? _____
When? _____ Who provided treatment? _____

What is the reason for your visit today?

□ STD Screening/Testing
□ Preventative Treatment
□ HIV Testing/Screening
□ I have a problem/infection
□ My partner was treated for an infection:
Chlamydia Gonorrhea
Syphilis Trichomoniasis
HIV I am not sure of the infection
Other _____

Did someone tell you to come in today?
□ No
□Yes, for Chlamydia or Gonorrhea
□Yes, for Syphilis

If yes, please tell us who asked you to come in:
Staff member from our clinic : _____
Partner: Name_____
DOB:_____
Other _____

Are you having any of the following symptoms?

□No
□ Pain / Fever / Bleeding
□ Abdominal Pain, Fever, Scrotal Pain, N/V
□ Discharge (vagina / penis / rectum) color: _____
□ Sores / Rash / Bumps: where _____
□ Blisters / Warts: where_____
□ Itching: where _____
□ Pain while urinating
□ Other _____

<u>For Men</u>
In the past 90days , have you:
Had sex with other men? __ YES __NO
If yes, do you top (where you place your penis in your sex partner's rectum)
□ YES □ NO
Do you bottom (where you receive your sex partner's penis in your rectum)
□ YES □ NO
Had sex in a public place like a bathhouse, book store, parking lot? □ YES □NO